

and performs the operation of making a double communication between the stomach and jejunum, usually on the posterior wall of the stomach, but does not exclude the Wölfler operation of making the openings in the anterior wall. The object of the double opening is to prevent the development of a vicious circle. With this method one can make a free communication between the stomach and jejunum and can make an extensive application of the serous surface of the one to that of the other. Each opening is 3 to 5 cm. long and they are separated from each other by about 2 cm. The proximal opening may be placed in a vertical direction, as Richard-Chenvrier, Moynihan, and Kausch recommended, and the distal opening in a transverse direction, parallel to the greater curvature of the stomach. Ruggi usually places both openings in the transverse direction.

Perforated Gastric Ulcer and its Relation to the Neutrophilic Leukocytes.—MANNHEIMER (*Mitt. a. d. Grenzgeb. d. med. u. Chir.*, 1911, xxiii, 553) says that the inflammatory leukocytosis in a perforating gastric ulcer case, in the beginning as well as in the further course of the disease, shows a changing picture. It is an apparently irregular, at any rate not so clear a picture as occurs in appendicitis, which is an inflammatory process from the beginning. This changing relation is explained as follows: The leukocytosis first appears with the participation of the peritoneum in the inflammation. Often, however, after a gastric perforation the inflammation is mild. The perforation may take place into the free peritoneal cavity, but the infection soon localizes itself to a portion of the cavity with the development of an encapsulated abscess. According to the varying virulence of the infection the process extends more or less widely and the stomach contents is extravasated into the abdomen. All these have a very variable influence on the blood picture, so that it assumes a special importance and may be a valuable aid in determining the character of the infection. The diagnosis of a perforating gastric ulcer is often much less dependent upon the symptoms of peritonitis than upon the other symptoms. With the establishment of the diagnosis operation is indicated. The inflammatory leukocytosis is of value for the prognosis in the beginning, but more especially in the further course of the disease. Here the leukocyte blood curve is of value. It gives information concerning the increase and decrease of the virulence of the inflammation and concerning the resistance of the body. It is also an important guide for treatment. The inflammatory leukocytosis deserves the consideration in connection with perforation of the stomach that is given to it in many other conditions.

Leverage Extension.—DEUTSCHLANDER (*Zentralbl. f. Chir.*, 1911, p. 1053) says that the method of nail extension in fractures has been employed for the purpose of traction only as its name implies. There are many forms of fracture in which the strongest traction will not reduce the deformity. In these it has been necessary to use leverage, torsion, and lateral traction. Whenever the fragment offers a suitable place for the application of a combined traction, which is the rule in diaphyseal fractures, its employment offers no difficulties, and it may obviate the necessity of an open operation in some cases. By

placing a nail in both fragments, a firm hold of each is obtained and a direct correcting pull may be exerted on both. By inserting a lever between the two nails a powerful leverage effect can be obtained. After proper preparation of the fracture region, and with local or general anesthesia, a good nickel-plated steel nail can be driven into each fragment. A dressing should then be applied, the heads of the nails being permitted to protrude beyond the dressing. Longitudinal traction is applied directly to the distal fragment. A lever is inserted between the two nails. The form of lever employed by Deutschlander is illustrated. It consists of a simple rod, bent downward like a hook, where it grasps the distal nail from above, to prevent sliding, and passing backward under the proximal nail to curve upward in a half circle, where it ends. Traction by rope and pulley is made from the free upper end of the curved rod on the proximal fragment, and, as already stated, directly from the nail in the distal fragment. The effect is to turn the fragments in the desired directions, and thus to correct the deformity. If the nails are made to perforate the fragments, the same apparatus may be applied on both sides. This method was employed in the case of a fracture of the lower end of the radius, of thirteen weeks' duration. Firm union had taken place with the lower fragment completely displaced on the dorsum of the radius and turned about 90 degrees on its axis so that the wrist-joint surface looked obliquely upward. Marked ankylosis of the wrist-joint, with very little flexion and extension and no rotation, were present, and there were severe sensory disturbances from pressure of the nerves over the fragments. Under vein anesthesia the fragments were separated with a periosteal elevator, and the leverage extension was applied. After twelve days the nails were removed and the deformity had been reduced. Ordinary treatment with massage and passive movements was followed by almost complete return of motion with disappearance of the sensory disturbances.

The Ejaculatory Ducts in Hypertrophy of the Prostate and the Sexual Functions after Freyer's Prostatectomy.—LEGUER and PAPIN (*Ann. d. mal. d. org. gén.-urin.*, 1911, ii, 1249 and 1356) present a study of this subject and report nine operations for this condition. In summarizing the results they say that in only 1 case was erection suppressed completely, and very slightly in another. Erection was normal and the sexual relations were performed in the other cases, but there was ejaculation to the exterior in only 3 cases. Suppression of the sexual appetite occurs only in the old and very feeble subjects. Erection appears to be preserved in the great majority of cases. The suppression of ejaculation is explained by the fact that in many cases the ejaculatory canals are broken. It therefore results that the orifice in the prostatic cavity is contracted, deformed, and may be obliterated, so that there may be retention of the spermatie fluid. It is probable that in many cases in which ejaculation of the fluid to the exterior does not occur, it takes place into the bladder. This ought to be especially true in those cases where there is rupture of the ejaculatory ducts, the orifices of which open into the prostatic cavity, the latter forming a portion of the bladder. External ejaculation requires the preservation of the verumontanum, which is a part of the floor of